STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 1, 2, 3, 4, 5, 2011 Facility number : 000321 Provider number: 155614 AIM number : 100286130 Survey team: Gloria J. Reisert, MSW/TC Dorothy Navetta RN Donna Groan RN Census bed type: SNF: 8 SNF/NF: 119 Total: 127 Census payor type: Medicare: 22 Medicaid: 86 Other: 19 Total: 127 Sample: 24 Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Lincoln Hills Health Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=E	Quality review 8/10/11 by Suzanne Williams, RN A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. A. Based on record review and interview, the facility failed to notify the physician of a blood sugar less than 60 as ordered. This deficient practice affected 2 of 10 residents reviewed with blood sugar monitoring in a sample of 24. (Resident # 124, #84)	F0157	The facility will continue to immediately inform the resident/responsible party and consult with the resident's physician when there is a significant change in the resident's physical status that may require an alteration in treatment.For Resident #124, the	08/29/2011

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	B. Based on record review and interview, the facility failed to notify the physician of a specimen not being collected as ordered for 1 of 1 resident being tested for Clostridium difficile in a sample of 24. (Resident #132) C. Based on record review and interview, the facility failed to notify the physician and responsible party when a lab test to check the folate level (a vitamin) for comparison was not drawn per order. This deficient practice affected 1 of 24 residents reviewed for lab work in a sample of 24. (Resident #70) Findings include: A. 1. The clinical record for Resident #124 was reviewed on 8/2/11 at 3:25 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus type II. The Nurse's Notes included, but were not limited to "3/20/11 8 P BS 56, Res given 2 puddings & juice. fam & MD notified. 9 P Recheck of BS (blood sugar) 47, Res given cup of medpass chocolate bar & peanut butter crackers. 10 P Recheck of BS 53, Res given chocolate bar & peanut butter crackers." The Blood Sugar Monitoring sheet dated March 2011 included, but was not limited		MD and resident/responsible party have been notified of the blood sugar results of 3/20/11. For Resident #84, the MD and resident/responsible party have been notified of the blood sugar results of 7/3/11 and 7/4/11. No new orders noted.Resident #132, was discharged from the facility on 5/14/11.For Resident #70, the folate has been drawn and the MD and resident/responsible party were notified of the lab draw and results.All residents with orders for accuchecks; orders for dementia work-ups and orders for labs related to stools for C-difficile have the potential to be affected. All licensed staff have been inserviced on P & P related to physician notification of abnormal blood sugar results; following physician orders for collection of specimens for labs for c-diff and dementia work-ups and notification to physician and resident/responsible party.Nursing Managers will complete weekly audits times 6 weeks; monthly audits times 2 months and then quarterly audits of all accuchecks to ensure that the physician/resident/responsible party have been notified of any abnormal results per facility policy.Nursing Managers will review the medical record weekly times 6 weeks; monthly times 2 months and then quarterly of those residents receiving orders for stool for C-diff to ensure that	

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	to: "Call MD if BS < 60 or > 450." Documentation was lacking the physician was notified after the blood sugar was rechecked at 9 and 10 P.M. which remained below 60. The Hypoglycemic Reaction (low blood sugar) policy and procedure provided on 8/3/11 by the DON included, but was not limited to "Nursing Interventions: Contact physician if blood sugar is below 60 unless there are specific call parameters. repeat accucheck as necessary until blood sugar level is stabilized..." A.2. Review of the clinical record for Resident #84 on 8/4/11 at 8:54 a.m., indicated diagnoses included, but were not limited to, diabetes mellitus. The August 2011 physician orders indicated the resident had an order dated 10/7/10 for accuchecks (blood sugar monitoring) before meals and at bedtime and for the physician to be notified whenever the blood sugars fell below 60 or above 450. Review of the "Insulin Sliding Scale Order" form indicated the resident's blood sugar was 47 on 7/03/11 and 40 on 7/04/11. Documentation was lacking of the physician being notified of the low blood sugars. During an interview with the Director of Nursing (DON) on 8/05/11 at 11:08 a.m., she indicated the supervisor for 7/03/11 indicated she thought she might have spoken with the physician regarding the low blood sugar of 47 but was not sure and did not document it. She indicated there was no documentation to indicate the physician was notified on the low blood sugar on 7/04/11.		the lab tests are completed according to physician orders and notification is made to physician/resident/responsible party.SS Director will review the medical record weekly times 6 weeks; monthly times 2 months and then quarterly of those residents with orders for a dementia work-up to ensure that lab tests are performed according to physician orders and that appropriate notification is completed.Results of above audits will be reported to the DON. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of four quarters. DON and Administrator to monitor.	

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	B. The clinical record for Resident #132 was reviewed on 8/3/11 at 12:45 p.m. A Physician Order dated 5/7/11 included, but was not limited to "Stool C-diff (Clostridium difficile - antibiotic associated diarrhea) check x (times) 3". Review of the Medication Administration Record May 2011 indicated specimens were obtained on 5/7, 5/8 at 3 a.m. and 5/8 at 11 a.m. The specimens were sent to the lab. Lab results indicated Specimen #1 was received on 5/8/11 and reported 5/8/11 at 17:22 (5:22 p.m.) as "none detected"; Specimen #2 was received on 5/8/11 and reported 5/9/11 at 11:52 a.m. as "none detected." A lab slip for Specimen #3 was not observed in the clinical record. On 8/3/11 at 1:25 p.m., the DON was asked to locate the results of Specimen #3. She was unable to locate the results in the clinical record. She contacted the Lab and the personnel informed her they only did Specimens #1 and #2 and discarded Specimen #3. Documentation was lacking the physician was notified Specimen #3 had not been resulted out. C. 1. Review of the clinical record for Resident #70 on 8/2/2011 at 11:45 a.m., indicated the resident had diagnoses			

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	which included, but were not limited to, personality disorder, anxiety, psychosis, depressive disorder, schizophrenia, mild mental retardation, and senile dementia. On 10/20/2010, a representative from the area mental health center completed an annual mental health assessment (PASRR - Pre-Admission Screening Resident Review Level II) due to the mental illness diagnoses. The recommendations included, but were not limited to, Diagnosis Review/Update by NF [nursing facility]; Dementia Work-up; Yearly RR [Resident Review] Required - (yearly not required if Dementia Dx [diagnosis] concrete); Needs Further Review; Other - Nursing home to update chart on appropriate diagnoses. The mental health agency had requested the nursing facility to clarify the dementia diagnosis - R/O [rule out] Dementia NOS [not otherwise specified]. On 10/27/2010, the consultant psychiatrist visited and recommended a dementia work-up with various lab tests and brain scans to be obtained if not performed in the last year, including the lab test RBC Folate [Red Blood Count]. The Folate lab had been completed on 5/13/2010. On 11/3/2010, the consultant psychiatrist visited again and requested the RBC			

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	Folate to be drawn again due to the previous one being low. Documentation was lacking of this lab having been drawn. Documentation was also lacking of the physician and the responsible party having been notified of the new lab order as well the lab not been drawn per order. During an interview with RN #1 on 8/2/2011 at 3:50 p.m., she indicated that after checking the clinical record, she was unable to locate where the lab had been drawn and of the physician and family having been notified of the order and of it not being drawn in 11/2010. She indicated she had just notified the psychiatrist who had given orders for it to be drawn the next lab day. 3.1-5(a)(3)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on record review and interview the facility failed to ensure physician orders were followed not to repeat a lab test if already completed and in the record. This deficient practice affected 1 of 2 residents reviewed with a Dementia workup in a sample of 24. (Resident #27)	F0282	The facility will continue to ensure that the services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.The nurse who scheduled the lab test for Resident #27 is no longer employed at the facility.For	08/29/2011

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	B. Based on record review and interview, the facility failed to obtain a lab test for comparison with a previous one in order to confirm or negate a dementia diagnosis as recommended by a level II mental health screening recommendation. This affected 1 of 3 residents reviewed for level II screenings in the sample of 24. (Resident #70) Findings include: A. 1. The clinical record for Resident #27 was reviewed on 8/4/11 at 9:47 a.m. The resident's diagnoses included, but were not limited to presenile dementia. A Physician Order from the psychiatric physician signed and dated 7/14/11 included, but was not limited to: "Dementia work-up as follows (if any of the following tests or procedures have been done within the past year and the report can be and is obtained, then omit the test or procedure): CBC (complete blood count with differential). The lab tests included but were not limited to the following: CBC Complete Bld (blood) CT (count) w/diff (with differential) reported 6/23/11 15:42 (3:42 p.m.) and received via fax at 3:28 p.m. 6/23/11. The lab reported on 7/18/11 at 23:42		Resident #70, the lab for folate has been completed. All licensed nursing staff were inserviced on following physician orders regarding lab tests ordered for a dementia work-up.SS Director will review the medical record weekly times six weeks; monthly times 2 months and then quarterly of those residents with orders for a dementia work-up to ensure that lab tests are performed according to physician orders and that appropriate notification is completed.Results of above audits will be reported to the DON. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of four quarters. DON and Administrator to monitor.	

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	(11:42 p.m.) the results of the CBC W/DIFF. On 8/4/11 at 2:25 p.m., in interview with the DON, after reviewing the labs, she indicated the "CBC did not need to be done." B.1. Review of the clinical record for Resident #70 on 8/2/2011 at 11:45 a.m., indicated the resident had diagnoses which included, but were not limited to, personality disorder, anxiety, psychosis, depressive disorder, schizophrenia, mild mental retardation, and senile dementia. On 10/20/2010, a representative from the area mental health center completed an annual mental health assessment (PASRR - Pre-Admission Screening Resident Review Level II) due to the mental illness diagnoses. The recommendations included, but were not limited to, Diagnosis Review/Update by NF [nursing facility]; Dementia Work-up; Yearly RR [Resident Review] Required - (yearly not required if Dementia Dx [diagnosis] concrete); Needs Further Review; Other - Nursing home to update chart on appropriate diagnoses. The mental health agency had requested the nursing facility to clarify the dementia diagnosis - R/O [rule out] Dementia NOS [not otherwise specified].			

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	On 10/27/2010, the consultant psychiatrist visited and recommended a dementia work-up with various lab tests and brain scans to be obtained if not performed in the last year, including the lab test RBC Folate [Red Blood Count]. The Folate lab had been completed on 5/13/2010. On 11/3/2010, the consultant psychiatrist visited again and requested the RBC Folate to be drawn again due to the previous one being low. Documentation was lacking of this lab having been drawn. During an interview with RN #1 on 8/2/2011 at 3:50 p.m., she indicated that after checking the clinical record, she was unable to locate where the lab had been drawn. 3.1-35(g)(2)			

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F0285 SS=D	A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a			

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	person with a related condition as described in 42 CFR 1009. Based on record review and interview, the facility failed to ensure Level II PASRR [Pre-Admission Screening Resident Reviews] for Diagnosis Review/Update recommendations were completed for 1 of 3 residents reviewed for Level II recommendations in a sample of 24 residents. (Resident #70) Finding includes: Review of the clinical record for Resident #70 on 8/2/2011 at 11:45 a.m., indicated the resident had diagnoses which included, but were not limited to, personality disorder, anxiety, psychosis, depressive disorder, schizophrenia, mild mental retardation, and senile dementia. On 10/20/2010, a representative from the area mental health center completed an annual mental health assessment (PASRR - Pre-Admission Screening Resident Review Level II) due to the mental illness diagnoses. The recommendations included, but were not limited to, Diagnosis Review/Update by NF [nursing facility]; Dementia Work-up; Yearly RR [Resident Review] Required - (yearly not required if Dementia Dx [diagnosis] concrete); Needs Further Review; Other - Nursing home to update chart on	F0285	The facility will continue to ensure Level II PASRR for Diagnosis Review/Update recommendations are completed.For Resident #70, the folate lab has been completed and consultant psychiatrist has been notified of the results. Progress note written to reflect review of the dementia work-up as ordered with no change in diagnosis made based on this review. Senile Dementia dx remains current for this resident.All residents with Level II PASRR for Diagnosis Review/Update recommendations have the potential to be affected.All licensed nursing staff were inserviced regarding following physician orders for lab tests ordered for dementia work-ups. SS Director will review the medical record weekly times six weeks; monthly times two months and then quarterly for those residents with Level II recommendations to ensure all orders were completed and that diagnoses were reviewed and updated as necessary. Results of above audits will be reported to the DON. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of four quarters. DON and Administrator to monitor.	08/29/2011

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	appropriate diagnoses. The mental health agency had requested the nursing facility to clarify the dementia diagnosis - R/O [rule out] Dementia NOS [not otherwise specified]. On 10/27/2010, the consultant psychiatrist visited and recommended a dementia work-up with various lab tests and brain scans to be obtained if not performed in the last year, including the lab test RBC Folate [Red Blood Count]. The Folate lab had been completed on 5/13/2010. On 11/3/2010, the consultant psychiatrist visited again and requested the RBC Folate to be drawn again due to the previous one being low. Documentation was lacking of this lab having been drawn. During an interview with the Director of Nursing [DON] on 8/3/2011 at 1:30 p.m., she indicated the labs and test results spoke for themselves as to the diagnosis. She indicated the psychiatrist ordered the tests but did not put into writing a note to definitely rule out or confirm the dementia diagnosis. She further indicated she thought the tests did rule out the dementia diagnosis but that the psychiatrist did not discontinue it and that she would have to have the psychiatrist confirm it on the next visit.			

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	7.5(c)(1) 7.5(c)(2) 7.5(c)(3) 7.5(c)(4)			
F0465 SS=C	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure the fans in the laundry were free of dust for 3 of 3 fans located in laundry. This deficient practice had the potential to affect 126 of 127 current residents who utilize the laundry services. Findings include: On 8/1/11 between 12:08 p.m. and 12:15 p.m., on entrance to the clean side of the laundry was a fan above the folding table. The fan had heavy dust on the grill and fan blades blowing on a stack of folded towels. On entering the room with the driers there was a fan on the left side blowing toward clean clothes on a rack. The fan had heavy dust on the grill and fan blades. Proceeding into the wash room there was a fan suspended on the wall near the outside door. Laundry Employee #1 was unloading gowns, sheets and towels being placed into a cart	F0465	The facility will continue to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.Fans in the laundry room have been cleaned.Cleaning schedule has been updated to include weekly sanitizing of the fans in the laundry room.During weekly rounds, the fans will be monitored for cleanliness. Results of these rounds will be reported to the Administrator weekly. Administrator will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of four quarters. DON and Administrator to monitor.	08/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

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	from the washer. The fan was blowing onto the clothing. The fan had heavy dust on the grill and fan blades. In interview with Laundry Employee #1, at this time, she indicated the fans are cleaned once a week. The Administrator provided a Preventative Maintenance Cleaning Schedule on 8/2/11 at 11:10 a.m. which lacked a date of the last cleaning. 3.1-19(f)			
F0502 SS=D	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview the facility failed to follow-up with lab for an ordered test for c-diff was obtained for 1 of 1 resident reviewed with stool specimens in a sample of 24. (Resident #132) Findings include: The clinical record for Resident #132 was reviewed on 8/3/11 at 12:45 p.m. A Physician Order dated 5/7/11 included, but was not limited to "Stool C-diff (Clostridium difficile - antibiotic associated diarrhea) check x (times) 3".	F0502	The facility will continue to provide or obtain laboratory services to meet the needs of its residents.Resident #132, was discharged from the facility on 5/14/11.All residents with orders for labs related to stools for C-difficile have the potential to be affected. All licensed staff have been inserviced on following physician orders for collection of specimens for labs for c-diff.Nursing Managers will review the medical record weekly times six weeks; monthly for two months and than quarterly of those residents receiving orders for stool for C-diff to ensure that the lab tests are completed	08/29/2011

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	Review of the Medication Administration Record May 2011 indicated specimens were obtained on 5/7, 5/8 at 3 a.m. and 5/8 at 11 a.m. The specimens were sent to the lab. Lab results indicated Specimen #1 was received on 5/8/11 and reported 5/8/11 at 17:22 (5:22 p.m.) as "none detected"; Specimen #2 was received on 5/8/11 and reported 5/9/11 at 11:52 a.m. as "none detected." A lab slip for Specimen #3 was not observed in the clinical record. On 8/3/11 at 1:25 p.m., the DON was asked to locate the results of Specimen #3. She was unable to locate the results in the clinical record. She contacted the Lab and the personnel informed her they only did Specimens #1 and #2 and discarded Specimen #3. 3.1-49(a)		according to physician orders.Results of these audits will be reported to the DON. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of four quarters. DON and Administrator to monitor.	

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review, observation and interview, the facility failed to ensure records were complete and accurately documented for 1 of 2 residents reviewed for hospice services and complete documentation of blood pressure monitoring for 1 of 4 residents reviewed with blood pressure monitoring in a sample of 24 residents. (Resident # 27, 124) Findings include: 1. On 8/2/11 at 4 p.m., the hospice RN (registered nurse) was observed charting at the East Hall nurse station. The clinical record for Resident #27 was reviewed on 8/4/11 at 9:47 a.m. The resident's diagnoses included, but were not limited to, failure to thrive. The resident was admitted to hospice on 7/22/11. Documentation was lacking in the clinical record of signed	F0514	The facility will continue to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.For Resident #27, a signed certification/order has been received.All residents receiving Hospice Services and those residents with an order for accuchecks have the potential to be affected.A meeting was held with the Hosparus Representative to review provisions within the Nursing Facility Agreement and noted responsibilities. Licensed Nursing Staff were inserviced regarding documentation of abnormal blood sugar results.SS Director will audit the medical records of those residents with orders for Hospice services weekly times six weeks; monthly times two months and then quarterly to ensure that the signed certification/orders are completed timely.Nursing Managers will complete weekly	08/29/2011

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	Certification/Orders. On 8/4/11 at 2:30 p.m., social worker #1 provided the Nursing Facility Agreement signed and dated 11/26/08. The Agreement included, but was not limited to: Responsibilities of Hospice "(j) copies of all orders issued by a Hospice Physician or an Attending Physician shall be provided to Facility in a timely manner. All physician orders communicated to Facility on behalf of Hospice in connection with the Plan of Care shall be in writing and signed by the applicable attending practitioner, provided however, that in the case of urgent or emergent circumstances such orders may be communicated by the practitioner orally and confirmed in writing thereafter. Hospice shall maintain adequate records of all practitioner orders communicated in connection with the Plan of Care...(l) IDG (Interdisciplinary Group) providing hospice Services to a Patient in the Facility will provide documentation of all services provided in Patient';s Facility medical record and in Patient's Hospice medical record. At the time of the IDG visit, written documentation will be entered in Patient's medical record with pertinent visit information . Facility/Hospice staff collaboration as well any physician notification. Hospice electronic documentation will be		audits times six weeks; monthly audits times two months and then quarterly of all accuchecks to ensure that results have been documented according to facility policy.Results of above audits will be reported to the DON. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a period of four quarters. DON and Administrator to monitor.	

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	completed within twenty-four(24) hours and delivered to the facility no later than the next routine visit. Facility may request and receive information from the Hospice medical record during routine business hours." On 8/5/11 at 8 a.m., the DON provided the Initial Certification signed and dated 7/27/11 by the Attending Physician faxed to the facility from the hospice on August 4 at 2:13 p.m. 2. The clinical record for Resident #124 was reviewed on 8/2/11 at 3:25 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus type II. The Nurse's Notes included, but were not limited to " 3/20/11 8 P BS 56, Res given 2 puddings & juice. fam & MD notified. 9 P Recheck of BS (blood sugar) 47, Res given cup of medpass chocolate bar & peanut butter crackers. 10 P Recheck of BS 53, Res given chocolate bar & peanut butter crackers." The next entry on the Nurse's Notes was 3/21/11 at 6:15 p.m. An insulin/blood sugar log indicated at HS (night no specific time) the blood sugar was 233. Documentation was lacking of another recheck after 10 p.m. 3.1-50(a)(1)			

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F0518 SS=D	3.1-50(a)(2) The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on record review and interview the facility failed to ensure laundry employees were trained on how to turn off the gas valve to the dryers in an emergency for 1 of 4 laundry employees interviewed. (Employee #2) Findings include: On 8/1/11 at 12:11 p.m., Laundry Employee #2 was asked "if there were a fire in the dryer, what would you do?" She indicated turn off the dryer. When queried if the dryers were gas, she indicated "Yes." When queried "where do you shut off the gas?" Laundry employee #1 indicated the main valve is out front to turn off." Laundry Employee #1 indicated "I didn't know that." On 8/5/11 between 10:30 a.m. and 12 p.m., personnel files were reviewed. Laundry Employee #2 had a hire date of 2/26/04. A skills checklist for the laundry was reviewed and lacked reference to training for the training related to turning	F0518	The facility will continue to train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.All laundry employees, including Employee #1, have been reinserviced regarding the location of the main gas shut off.All employees have been inserviced again of the location of the main gas shut off.General orientation checklist for all new employees does include location of the main shut off for all utilities, including main gas shut off. Semi-annual inservice training, including main shut off for all utilities, will continue to be completed with all employees. The post-test has been updated to include location of main gas shut off.A summary of the completion of the inservice training will be submitted to the QA Committee quarterly for a period of four quarters. DON and Administrator to monitor.	08/29/2011

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	off the gas valve in an emergency. In interview with the Maintenance Director on 8/5/11 at 11:50 a.m., he indicated he tells the employees where the main shut off valves are when they are hired. He doesn't do any inservices or write it down anywhere. 3.1-51(b)			
F9999	State Findings 3.1-14 PERSONNEL A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test , using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department- approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee	F9999	The facility will continue to ensure that employees and nonpaid personnel are screened for tuberculosis by receiving a two-step tuberculin skin test.Volunteer #1 received 1st step ppd on 8/5/11 and is scheduled to receive his second step.CNA #1 is no longer employed at the facility.Receptionist and Staff Development Coordinator have been educated regarding timely completion of two-step ppds for all employees and necessary nonpaid personnel.Receptionist will audit all employee and necessary nonpaid personnel records monthly for a period of one year. Results of audits will be reported to the Business Office Manager monthly. Additional training and education will be completed monthly as necessary based on the results of	08/29/2011

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	starting work. The facility must assure the following: At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This State Rule was not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure volunteers were screened for tuberculosis at the time of service or within one month prior to service and failed to ensure employees received a second step test within 3 weeks after the first step. This deficient practice affected 1 of 1 volunteer and 1 of 10 employee files that were reviewed. (Volunteer #1, CNA #1) Findings include:		these audits.	

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	1. On 8/5/2011 at 9:25 a.m. during an interview with the Administrator, she indicated she was not sure if Volunteer #1 had received a PPD [a skin test for tuberculosis] and would have to check his file. A few minutes later, she returned and indicated she had checked his file and also with the [name of volunteer agency] to determine if they had administered him one. She indicated she was unable to locate documentation of the volunteer having received a PPD skin test in the last year and presented a copy of where he had received it on this day. Random observations on 8/1, 8/2, 8/3, 8/4, and 8/5/2011, noted the volunteer and his therapy dog visiting and interacting with the residents throughout the facility. 2. On 8/5/2011 at 11:30 a.m., record review of Certified Nurses Aide (CNA) # 1 employee file lacked documentation that a second step PPD had been done. Record review indicated CNA #1 was hired on 6/16/2011 and resigned her position on 8/2/2011. On 8/5/2011 at 12:30 p.m., in interview with Business Office Manager # 1, she indicated the second step PPD had not been done and does not know why it "got dropped".			

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	3.1-14(t) 3.1-14(t)(1)			